Implementation Plan for the Healthy Children initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

NOTE: The Australian Government may publish all or components of this jurisdictional implementation plan, following initial consultation with the jurisdiction, without notice in public documents pertaining to the National Partnership Agreement.

PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health and should be read in conjunction with that Agreement. The objective in the National Partnership is to address the rising prevalence of lifestyle related chronic diseases, by:

   1.1 laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and

   1.2 supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

   The measures funded through this Agreement include provisions for the particular needs of socio-economically disadvantaged Australians, and those, especially young women, who are vulnerable to eating disorders.

2. The Healthy Children initiative provides funding to support implementation of healthy lifestyle programs in childhood settings across Australia.

3. Under the Healthy Children initiative jurisdictions are responsible for developing programs that may include a range of different activities. Some of these activities may be grouped according to similarities.

TERMS OF THIS IMPLEMENTATION PLAN

4. This Implementation Plan will commence as soon as it is agreed between the Commonwealth of Australia, represented by the Minister for Health and Ageing, and the State of Victoria, represented by Hon. David Davis MLC, Minister for Health (known as the Parties to this Implementation Plan).

5. This Implementation Plan may be varied by written agreement between authorised delegates.

6. This Implementation Plan will cease on completion of the specified program, including the acceptance of final performance program reporting and processing of final payments against performance benchmarks specified in this Implementation Plan.

7. Either Party may terminate this agreement by providing *30 days* notice in writing. Where this Implementation Plan is terminated, the Commonwealth's liability to make payments to the State is limited to payments associated with performance benchmarks achieved by the State by the date of effect of termination of this Implementation Plan.

8. The parties to this Implementation Plan do not intend any of the provisions to be legally enforceable. However, that does not lessen the parties' commitment to this Implementation Plan.

FINANCIAL ARRANGEMENTS

9. The maximum possible financial contribution to be provided by the Commonwealth for the Healthy Children initiative is $78.494 million. Payments will be structured as 50 percent facilitation and 50 percent reward. The reward payments are conditional on achievement against performance benchmarks specified in the National Partnership.

10. Facilitation payments will be payable in accordance with Table 1 from July 2011 to 2014 in accordance with the National Partnership. All payments are exclusive of GST.

Table 1: Facilitation and Reward Payment Schedule ($ million)

Facilitation Payment		Due date	Amount
(i)	Facilitation payment	July 2011	$7.83
(ii)	Facilitation payment	July 2012	$15.65
(iii)	Facilitation payment	July 2013	$7.78
(iv)	Facilitation payment	July 2014	$7.99
Reward Payment *		Due date	Amount
(v)	Reward payment	2013-2014	$15.70
(vi)	Reward payment	2014-2015	$23.55

* note the actual amount of reward payment is conditional on assessment of achievement against performance benchmarks as set out in the National Partnership

Any Commonwealth financial contribution payable will be processed by the Commonwealth Treasury and paid to the State Treasury in accordance with the payment arrangements set out in Schedule D of the *Intergovernmental Agreement on Federal Financial Relations*.

OVERALL BUDGET

11. The overall program budget (exclusive of GST) is set out in Table 2.

Table 2: Overall program budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
(i) Health promoting early childhood services and schools	5.57	5.57	5.57	5.57	22.28
(ii) Healthy children and families as part of communities	4.255	4.255	4.255	4.255	17.02
TOTAL	9.825	9.825	9.825	9.825	39.25*

Notes: Facilitation payment only. Does not include Victorian government funding.

12. Having regard to the estimated costs of program and associated activities specified in the overall program budget, the State will not be required to pay a refund to the Commonwealth if the actual cost of the program is less than the agreed estimated cost. Similarly, the State bears all risk should the costs of the program and/or a project(s) exceeds the estimated costs. The Parties acknowledge that this arrangement provides the maximum incentive for the State to deliver projects cost-effectively and efficiently.

PROGRAM OVERVIEW AND OBJECTIVE

13. **Healthy children and families Victoria**

14. The objective in this program is to develop health promoting early childhood services, schools and communities to increase fruit and vegetable consumption and physical activity rates in children, adolescents and families.

15. Healthy children and families Victoria is inclusive of the following activities:

Activity 1: Health promoting early childhood services and schools

Activity 2: Healthy children and families as part of communities

16. The contact for this program is the Prevention and Population Health Branch, Department of Health Victoria (ph 03 9096 1487)

ACTIVITY DETAILS

NOTE: This section must be completed for each activity under the program (for example, if five activities comprise the program, then Clauses 18 to 32 must be cut and pasted and completed for each activity). Where there are a large number of activities, consider rolling up some of these activities into sub-groups (for example, if there are five capacity building type activities, they could be reported as one activity under the banner of capacity building).

17. **Activity 1:** Health promoting early childhood services and schools

18. **Overview:**

A health promoting schools and early childhood settings program will be developed, based on a number of Victorian programs including Kids – 'Go for your life', Fun n Healthy in Moreland, Romp n Chomp, It's Your Move, and Colac BE Active Eat Well. This streamlined program will be extended to early childhood services and schools.

The program will work within a health promoting schools framework, requiring schools and services to take a whole-of-school approach and implement changes in the curriculum, teaching and learning environment; support school organisation, culture and policy and physical environment; and through partnership activities with parents and the community. Schools will focus on the areas of nutrition and physical activity, and healthy living.

A range of statewide strategies will support early childhood services, primary and secondary schools to implement the program including:

- Health Promoting Schools Victoria – provision of support to being a 'health promoting early childhood service or school'. It will achieve this through professional development, 'how to' tools and resources, 'health promoting schools' network, and evaluation and research.

- Early Childhood Nutrition/Canteen Advisory Service – provision of support to increase the availability of healthy food/drinks, and decrease the availability of unhealthy food and drink, in line with the DEECD Children Services Regulations (to be replace with the National Quality Standards Framework from January 2012), School Canteens and Other School Food Services Policy and Regulations. It will achieve this through professional development, menu assessment, and information and online resources.

- Implementation of the Victorian Healthy Canteen Guidelines for Schools and Healthy Food and Drink Guidelines in community settings that reach children and their families, such as commercial playgrounds, party venues, health services and recreational facilities (such as swimming pools).

19. **Outputs:**

Output	**Quantity**	**Quality**	**Timeframe**
Number of schools participating in health promoting schools Number of early childhood services, participating in health promoting early childhood services and schools Victoria	Up to 72% of government primary schools Up to 20% of government secondary schools (new initiative) Up to 55% or early childhood services	See evaluation, outcomes & performance benchmark measurement.	2014/15 - Final report

Notes: Victoria is undertaking a significant dose to population approach ie. This initiative is aimed at a significant dose of intervention rather than a significant population reach with less dose.

20. **Outcomes:**

Activity	Long term outcomes (2014/15) *
Activity 1: Health promoting early childhood services and schools	• Proportion of children at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by children to meet targets • Increase in proportion of children participating in moderate physical activity each day by 15 per cent

* see NPAPH Performance Benchmarks for details

21. **Rationale:**

The 'health promoting schools' framework (www.iuhpe.org) recognises that schools are complex organisations and encourages schools to take a 'whole-of-school' approach to implement changes in the curriculum, teaching and learning environment; support school organisation, culture and policy and physical environment; and through partnership activities with parents and the community.

There is strong evidence that the health promoting schools approach is effective in improving health and educational outcomes. The health promoting schools approach can impact on health and wellbeing especially in the areas of nutrition and physical activity, contributes to the development of individual skills and factors in the school environment such healthy policies and school culture, and enhances parental participation in the school community (Stewart-Brown, 2006).

This framework provides a generic platform for considering a number of key health promotion areas that also embraces early childhood services. 'Promoting mental health in schools and early childhood education and care settings' is a joint initiative between the Department of Education and Early Childhood Development and the Department of Health where a health promoting schools framework is being developed to promote mental health in schools.

Evaluation of school programs KGFYL (Prosse et al, 2009), Romp n Chomp (de Silva-Sangorski et al, 2010), Fun N Healthy in Moreland (unpublished) indicate the effectiveness of the health promoting schools framework. Rather than a number of disparate programs, 'health promoting early childhood services and schools' will create a streamlined program that maximizes the synergies and minimizes cost of these activities.

Further, current statewide support programs that provide professional development, resources and tools etc such as 'Start Right, Ear Right', 'Canteen Advisory Service' and 'Fruit n Veg for Schools' have been identified as essential to expanding support to the implementation of a health promoting schools approach. Review of the work of the Canteen Advisory Service and its work in supporting the Department of Education and Early Childhood Development (DEECD) healthy canteens policy has facilitated significant improvements in healthy food provision in primary schools. Our review concluded that this advisory service model could be applied to other nutrition programs and healthy food supply strategies. This type of service will therefore be extended to secondary schools.

References:

de Silva-Sanigorski A, Bell AC, Kremer P, Nichols M, Crellin M, Simth M, Sharp S, de Groot F, Carpenter L, Boak R, Robertson N, Swimburne B. Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. American Journal of Clinical Nutrition 2010; 91: 831-840.

Prosse L, de Silva-Sanigorski A, Carpenter L, Hoinsett S, Gibbs L, Swinburne B, Waters E. Evaluation of the Kids – 'Go for your life' intervention in Australia primary schools. 2009. Report to the Department of Health.

Stewart-Brown S. 2006. What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promotion schools approach? Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; wwww.euro.who.int/document/e88185.pdf).

22. **Contribution to performance benchmarks:**

See outputs, outcomes and evaluation sections.

23. **Policy consistency:**

NPAPH and Healthy Children Scoping Statement and Guiding Policy Principles

Health promoting early childhood services and schools is consistent with the objectives of the NPAPH to improve nutrition and increase levels of physical activity in children. It is also consistent with the outputs, scope and policy principles of the Healthy Children initiative as detailed in the Healthy Children Scoping Statement and Guiding Policy Principles (see attachment A).

This activity is consistent with broader Victorian preventive health reforms, preventive health policies and specific directions in healthy children.

24. **Target group(s):**

Early childhood services and schools across the state.

25. **Stakeholder engagement:**

The health promoting early childhood services and schools program will be negotiated through the Child Health Coordination Group (DEECD and DH) and in consultation with VicHealth, Cancer Council Victoria, National Heart Foundation Victoria, and Diabetes Australia Victoria.

The department has established a technical advisory group to guide the design of the NPAPH, based on evidence, and in the evaluation. Members of the group have expertise in health economics, health inequalities, obesity prevention, complex community interventions and interventions in a variety of settings such as workplaces and includes Professor Boyd Swinburne (Deakin University), Professor Penny Hawe (University of Calgary), Professor Alan Shiell (University of Calgary), Professor Rob Carter (Deakin University), Professor Elizabeth Waters (University of Melbourne), Professor Tony La Montagne (University of Melbourne) and Dr Sharon Goldfeld (Department of Education and Early Childhood Development).

26. **Risk identification and management:**

Risk	Level	Mitigation strategy	Responsibility/timeline
Delays in recruitment or failure to attract suitable staff	Medium	Investigation of workforce requirements will be undertaken in late 2010	Prevention and Population Health Branch (PPHB)

Staff turnover and knowledge retention	Low	Knowledge retained at regional level with regional public health team and state level through statewide support services and network	PPHB
Engagement of early childhood services and schools	Low	Maintain regular engagement with existing stakeholders Health promoting schools network to support staff with engagement strategies Current engagement exists via existing discrete programs Secondary schools are a new initiative	PPHB

27. **Evaluation:**

Activity	**Methodology**	**Timeframe**
Activity 1: Health promoting early childhood services and schools As Healthy Children's activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Children Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it. While not yet fully articulated, it is also intended that the Victorian evaluation approach should contribute to a National approach where possible.	Process review and (aggregated) discrete program level evaluation in selected areas from the outset using qualitative designs, will be design to provide lessons learnt/ insights. The use of supplementary school-based data is being investigated.	The modelled Victorian baseline from the 07/08 NHS and enhanced VPHS 2013 and 2014 will provide statewide outcomes data for children specifically. Supplementary school-based data is being investigated for evaluation scheduling and utility based on KGFYL evaluation experience.

28. **Infrastructure:**

If required, additional infrastructure for Activity 1: Health promoting early childhood services and schools program will be provided by the Prevention and Population Health Branch, Victorian Department of Health.

29. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
(i) Health Promoting Schools Coordinator Positions established	2011
(ii) Publicity, communications and social marketing strategies developed	2011-12
(iii) Preventive Health Awards Program developed	2011-12
(iv) Program support fund established	2011
(iv) Training and development: "Leadership for Health" Statewide Program for school principals operational	End 2011
(v) Healthy canteen recognition and accreditation program	2011
(v) Workplan of rollout of interventions developed: for healthy living programs on site and in the community e.g. healthy eating and physical activity policy guidelines	Nov 2011to 2014

Notes:

30. **Responsible officer and contact details:**

The Prevention and Population Health Branch, Department of Health Victoria (ph 03 9096 1487)

31. **Activity budget:**

Table 4: Activity project budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	5.57	5.57	5.57	5.57	22.28

Notes: NPAPH facilitation payment only. Does not include Victorian government funding.

32. **Activity 2:** Healthy children and families as part of communities

33. **Overview:**

The department will provide a framework of interventions that can be applied across settings and within population groups for selected communities (see Figure 1). In addition to schools, other settings include home and family and community, that influence a child's eating, activity and weight, will be targeted.

The program will be locally driven in the selected communities by new local governance structures in communities with representation from local business and industry, early childhood centres and schools, local health system and services, local government, non-government sector and community.

A mass media community-wide campaign will be developed and run over the four years of the agreement, with particular focus on physical activity and healthy eating messages targeting children,

families and adolescents. This will complement Measure Up. A smaller intervention will be developed as a subcomponent to assess the use of a targeted digital media (web 2.0) strategy utilising mobile phones and iPad applications (apps) for adolescent message dissemination and uptake.

A range of parent and family community education and peer education programs to improve health literacy will be undertaken including programs that look at pregnancy weight gain, first-time mothers (eg InFant), low-intensity self management programs for women (eg Help-er), peer education programs (eg Family Food Patch).

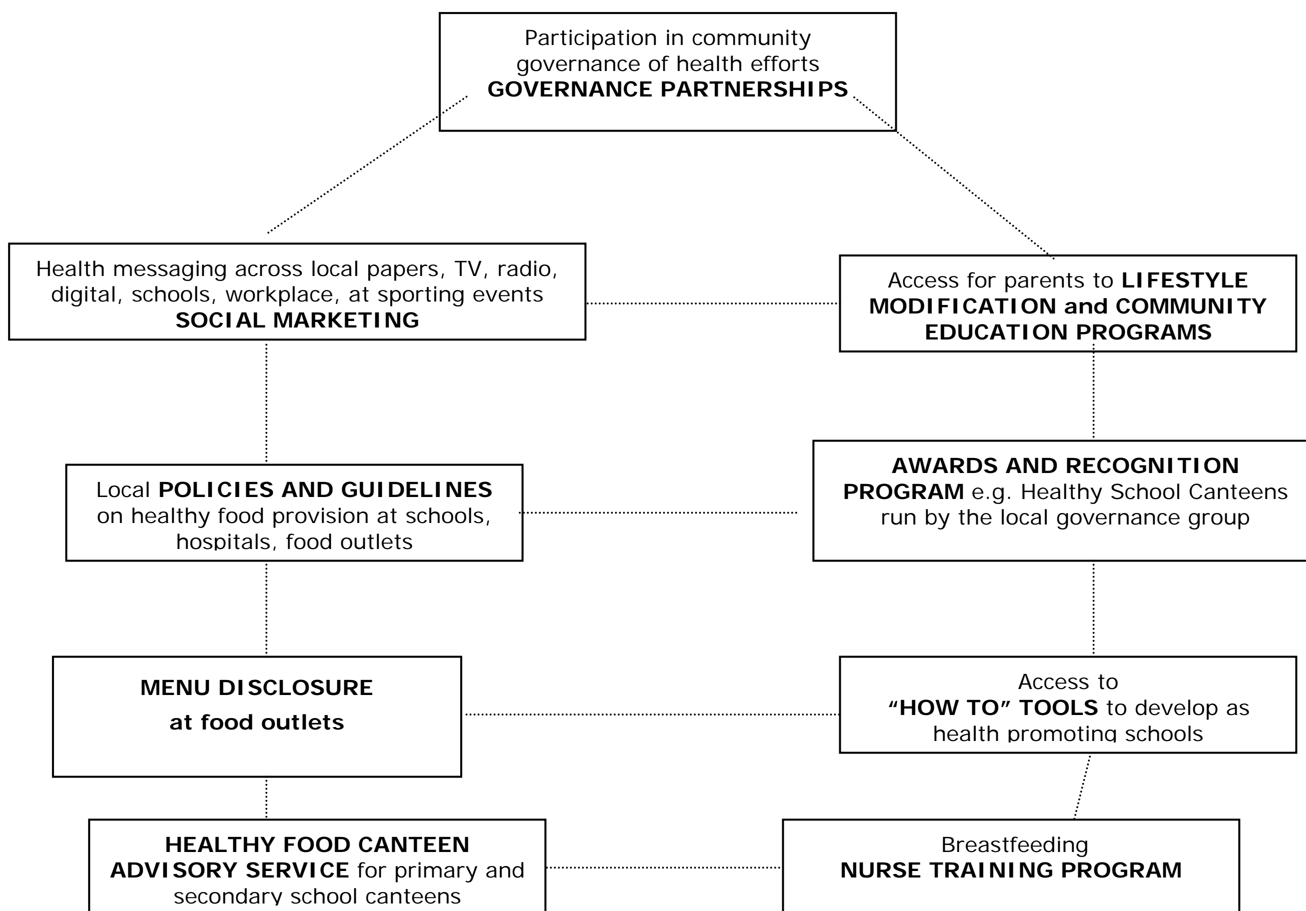
Early childhood services and schools will have access to ‘how to’ tools to develop as health promoting schools and provided with support to implement the health promotion schools approach for nutrition and physical activity outcomes (based on lessons learnt from Kids - *Gfyl* - funded local government areas, Romp and Chomp, Colac Be Active Eat Well, Fun n Healthy in Moreland). Support will also be provided to increase the availability of healthy food and drinks, in line with early childhood services and DEECD School Canteens and Other School Food Services Policy and Regulations.

Healthy food provision and menu disclosure will be marketed and supported at food outlets, hospitals, recreation facilities, workplaces, government organisations, local government, community events etc. This will enable children and their families to be able to purchase healthy food options outside of the school and home. The Healthy Choices: Food and Drink Guidelines for Victorian Public Hospitals will form the basis for local and food and catering guidelines and policies while a menu disclosure system and award and recognition programs for food outlets will be considered.

Incentives to increase the supply of healthy foods, skill building and healthy food promotion such as Foodcents will also be considered.

These interventions will be based on best available evidence, built on existing investments where possible and be flexible so that as evaluation proceeds, lessons and evidence can be incorporated quickly.

Figure 1: A comprehensive set of strategies to take action on preventive health for children and their families at a community level



34. **Outputs:**

Output	Quantity	Quality	Timeframe
Activity 2: Number of communities and schools and early childcare settings within these communities	Approximately 25 to 35 communities (more disadvantaged) with populations ranging from 10,000 to 70,000 (then the children/families within these populations) Final number will depend on costing and adjacent geo-locations)	See evaluation, outcomes & performance benchmark measurement.	2014/15 – Final report

Notes: Victoria is undertaking a significant dose to population approach ie. This initiative is aimed at a significant dose of intervention rather than a significant population reach with less dose

35. **Outcomes:**

Activity	**Long term outcomes (2014/15)**
Activity 2: Children and families as part of communities	• Proportion of children at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by children to meet targets • Increase in proportion of children participating in moderate physical activity each day by 15 per cent

36. **Rationale**

Birch and Ventura (2009) found that school-only based interventions had little success and those that did show significant effects, the effect sizes are small compared to relative population level increases in obesity. An ecological framework highlights that a child's weight status is influenced by a range of factors and schools are only one of several contexts for change. This framework highlights that preventive health interventions should be implemented across the multiple contexts that can influence a child's eating, activity and weight. In addition to schools, other contexts include home, family and community.

Community-level interventions in preventive health are increasingly being utilised across Australia and internationally - Colac Be Active Eat Well in Victoria (Sanigorski et al, 2008), EPODE in France (Roman et al, 2009), OPAL (Obesity Prevention and Lifestyle) in South Australia. Other countries are also investing in community-based interventions to address obesity. The United Kingdom is investing £30 million pounds stirling over three years in nine communities to address obesity as part of their *Healthy Weight, Healthy Lives* strategy. The United States has recently announced Communities Putting Prevention to Work, an initiative to support community-level interventions in selected communities to address obesity.

The Victorian Department of Health (Centre for Allied Health, 2009) commissioned a rapid review of the research evidence on community level interventions to reduce obesity which supports their effectiveness when based on the following core elements: integrated and comprehensive program, across multiple settings; using multiple interventions, targeting change at the individual, group and organisation levels; involves the community in planning, implementation and evaluation, and; uses multiple individual-level intervention strategies.

The success of 'healthy children and families as part of a community' in Victoria will be determined by integration with a comprehensive and complementary program of interventions that children and their families can access in the community as well as creating supportive environments for individuals and families to adopt healthier lifestyles. 'Healthy children and families' requires integration with the broader directions of the NPAPH in Victoria. The approach in Victoria will be a significant and sustained 'whole-of-community' approach to settings that influence behaviour change.

A community approach sees sustained, consistent and coordinated action across community, family, council(s), schools, early childhood settings, health services and workplaces. This is complemented by the same levels of action at a statewide level. The range of interventions proposed is supported by the evidence. Evidence summaries produced by the Prevention and Population Health Branch, Victorian Department of Health (2010), concluded that:

- Interventions targeting parents and families have been successful in increasing healthy eating in children aged 4-6 months to 4 years. Examples include group and peer models.

- Parental involvement is important in achieving sustained behavioural change in pre-school and primary children.

- Interventions that have taken a whole-of-school approach have shown positive healthy eating outcomes. Local examples include Romp N Chomp (de Silva-Sanigorski et al 2010) and Colac Be Active Eat Well (Sanigorski et al 2008).

- Programs that train and support staff in child care services on meeting children's dietary needs are effective. 'Start Right, Eat Right' is a Victorian example of this program.

- Findings from school canteen evaluations indicate that tools and resources can be used successfully to reorientate menus to healthier options. Consideration should be given to services catering to children and families (eg commercial playgroups, recreational facilities) and the provision of healthy food and drinks.

- Community wide activities have been shown to enhance the outcomes of school based programs.

Social marketing that uses technologically-based interventions targeting adolescents has been identified as a need (Tercyak et al, 2009). Freeman and Chapman (2008) believe that there is a vast untapped potential for health practitioners and researchers to exploit web 2.0 media for health promotion.

An evaluation strategy across all partnership initiatives has been developed (see evaluation section). Funding will be allocated across the initiatives for evaluation. The collective benefit to each partnership initiative is therefore greater than the individual contribution. The Victorian government is committed to research and evaluation to deliver the best possible outcomes for Victorians as demonstrated in the establishment of the Centre of Excellence in Intervention and Prevention Science (CEIPS).

References:

Birch LL, Ventura AK. Preventing childhood obesity: what works? International Journal of Obesity 2009: 33; 74-81.

Cross-Government Obesity Unit, Department of Health and Department of Children, Schools and Families. 2008. Healthy Weight, Healthy Lives: a Cross –Government Strategy for England. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf

de Silva-Sanigorski A, Bell AC, Kremer P, Nichols M, Crellin M, Simth M, Sharp S, de Groot F, Carpenter L, Boak R, Robertson N, Swimburne B. Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. American Journal of Clinical Nutrition 2010; 91: 831-840.

Freeman B, Chapman S. Gone viral? Heard the buzz? A guide for public health practitioners and researchers on how Web 2.0 can subvert advertising restrictions and spread health information. Journal of Epidemiology and Community Health 2008;62:778-782.

Prevention and Population Health Branch, Victorian Department of Health. 2010. Increasing healthy eating for children aged 4-6 months to 4 years. An evidence summary. http://www.health.vic.gov.au/healthpromotion/downloads/increasing_fruit_vege5-12years.pdf

Prevention and Population Health Branch, Victorian Department of Health. 2010. Getting children aged 5 to 12 years eating more fruit and vegetables. An evidence summary. http://www.health.vic.gov.au/healthpromotion/downloads/healthy_eating_6_months.pdf

Romon M, Lommez A, Tafflet M, Basdevant A, Oppert JM, Bresson JL, Ducimetière P, Charles MA, Borys JM. Downward trends in the prevalence of childhood overweight in the setting of 12-year school- and community-based programmes. Public Health Nutrition 2009; 12(10): 1735-42.

Sanigorski AM, Bell AC, Kremer PF, Cuttler R, Swinburn BA. Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. International Journal of Obesity. 2008; 79: 1-8.

The Centre for Allied Health Evidence. 2009. Community-based interventions: A rapid review. A technical report prepared for Department of Health, Victoria. http://www.health.vic.gov.au/healthpromotion/downloads/cbi_full_report_final.pdf

Tercyak KP, Abraham AA, Graham AL, Wilson LD, Walker LR. Association of multiple behavioural risk factors with adolescents' willingness to engage in eHealth promotion. Journal of Paediatric Psychology 2009; 34 (5); 457-469

US Department of Health and Human Services. 2010. Communities Putting Prevention to Work. www.cdc.gov/chronicdisease/recovery/

37. **Contribution to performance benchmarks:**

See outputs, outcomes and evaluation sections.

38. **Policy consistency:**

NPAPH and Healthy Children Scoping Statement and Guiding Policy Principles

Health promoting early childhood services and schools is consistent with the objectives of the NPAPH to improve nutrition and increase levels of physical activity in children. It is also consistent with the outputs, scope and policy principles of the Healthy Children initiative as detailed in the Healthy Children Scoping Statement and Guiding Policy Principles (see attachment A).

This activity is consistent with broader Victorian preventive health reforms, preventive health policies and specific directions in healthy children.

39. **Target group(s):**

Targeted effort will be directed towards approximately 25 to 35 more disadvantaged Victorian communities, a combination of metropolitan and regional, with high-risk profiles (based on the Victorian Population Health Survey 2008, Victorian Child and Adolescent Monitoring System, Victorian Best Start and Neighbourhood Renewal data, WorkHealth data) and sufficient capacity to utilise external support.

40. **Stakeholder engagement:**

The Health promoting early childhood services and schools program will be negotiated through the Child Health Coordination Group (DEECD and Dept Health) and in consultation with VicHealth, Cancer Council Victoria, National Heart Foundation Victoria, and Diabetes Australia Victoria.

The department has established the Victorian Local Government Health and Wellbeing Planning Advisory Group to provide direction and high-level strategic advice and recommendations on government policy and planning including the NPAPH.

The department has established a technical advisory group to guide the design of the NPAPH, based on evidence, and in the evaluation. Members of the group have expertise in health economics, health

inequalities, obesity prevention, complex community interventions and interventions in a variety of settings such as workplaces and includes Professor Boyd Swinburne (Deakin University), Professor Penny Hawe (University of Calgary), Professor Alan Shiell (University of Calgary), Professor Rob Carter (Deakin University), Professor Elizabeth Waters (University of Melbourne), Professor Tony La Montagne (University of Melbourne) and Dr Sharon Goldfeld (Department of Education and Early Childhood Development).

41. **Risk identification and management:**

Risk	Level	Mitigation strategy	Responsibility/timeline
Managing local government expectations/issues re community selection	Medium	Consulting with MAV and LG Advisory Group Joint DH-MAV position Working with regional public health teams who have direct ongoing relationships with local government through Municipal Public Health Planning	Prevention and Population Health Branch (PPHB)
Delays in establishing local governance and undertaking local level planning	Medium	Regional public health teams engaged in program	PPHB

42. **Evaluation:**

Activity	Methodology	Timeframe
Activity 2: Children and families as part of communities As Healthy Children activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Children Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it. While not yet fully articulated, it is also intended that the Victorian evaluation approach should contribute to a National approach where possible.	In addition to the existing 2008 and 2011 Victorian Population Health Survey (VPHS)-LGA behavioural measures of adults and parents, a baseline survey, will cover key behavioural mediator variables (not currently measured) such as awareness, instrumental and affective attitudes, perceived control and self-efficacy and behavioural intentions. An approach to measuring children's height and weight in the intervention and comparison communities only is being investigated for feasibility and cost. These measures will be taken selected target intervention communities, and selected comparison communities, to create a quasi-experimental design, to allow for assessment of both between area and within area effects between 2011 and 2013. Process review and discrete program level evaluation in selected areas from the outset using qualitative designs, will be designed to provide lessons learnt/ insights.	2011 Parent baseline using VPHS-LGA (for selected communities). 2014 Post-test using VPHS-LGA 2010/2011 Baseline mediator survey in selected intervention and comparison areas. 2013 Post-test mediator survey in selected intervention and comparison areas 2010-2013 Qualitative process review and case studies (a component of a community-wide evaluation to be undertaken with selected communities) 2014 Evaluation Report and peer-reviewed publications An approach to measuring children's height and weight is being investigated for implementation in 2011 and 2014.

43. **Infrastructure:**

If required, additional infrastructure for Activity 2: children and families as part of communities will be provided by the Prevention and Population Health Branch, Victorian Department of Health.

44. **Implementation schedule:**

Table 3: Implementation schedule

	Deliverable and milestone	Due date
Activity 2: Healthy children and families as part of communities		
(i)	Selection of communities and sign-up of LGAs	July 2011
(ii)	Community governance group (LGA level) established	July 2011
(iii)	Community - organisation/schools and child care settings and services baseline data and evaluation established	2011
(iv)	Preventive health promotion positions established	2011
(v)	Communications and social marketing strategies developed and implemented	End 2011
(vi)	Community action and workplan of interventions developed: for healthy living programs in schools and early childhood settings and services and in the community e.g. healthy shopping and cooking, lifestyle challenge; healthy eating and physical activity policy guidelines; calorie disclosure at fast food outlets; healthy food promotions	2011-14

Notes: This Activity will be delivered and coordinated with Activity 2 of the Healthy Worker Initiative.

45. **Responsible officer and contact details:**

The Prevention and Population Health Branch, Department of Health Victoria (ph 03 9096 1487)

46. **Activity budget:**

Table 4: Activity project budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	4.255	4.255	4.255	4.255	17.02

NOTES:

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

47. The Commonwealth is responsible for reviewing the State's performance against the program and activity outputs and outcomes specified in this Implementation Plan and providing any consequential financial contribution to the State for that performance.

Role of the State

48. The State is responsible for all aspects of program implementation, including:

    (a) fully funding the program, after accounting for financial contributions from the Commonwealth and any third party;

    (b) completing the program in a timely and professional manner in accordance with this Implementation Plan; and

    (c) meeting all conditions of the National Partnership including providing detailed annual report against milestones and timelines contained in this Implementation Plan, performance reports against the National Partnership benchmarks, and a final program report included in the last annual report that captures lessons learnt and summarises the evaluation outcome.

49. The State agrees to participate in the Healthies Steering Committee or other national participation requirements convened by the Commonwealth to monitor and oversee the implementation of the initiative, if relevant.

PERFORMANCE REPORTING

50. The State will provide performance reports to the Commonwealth to demonstrate its achievement against the following performance benchmarks as appropriate to the initiative at 30 June 2013 and 31 December 2014:

    a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of children at healthy weight returned to baseline level by 2015.

    b) Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2013; 0.6 for fruits and 1.5 for vegetables by 2015.

    c) Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each State by five per cent by 2013; by 15 per cent by 2015.

    d) Increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of adults at healthy weight returned to baseline level by 2015.

    e) Increase in mean number of daily serves of fruits and vegetables consumed by adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2013; 0.6 for fruits and 1.5 for vegetables from baseline by 2015.

    f) Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline for each state by 2013; 15 per cent from baseline by 2015.

    g) Reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013.

51. The requirements of performance reports will be mutually agreed following confirmation of the specifications for measuring performance benchmarks by the Australian Health Minister's Conference.

52. The performance benchmarks for the State will be monitored and independently assessed by the COAG Reform Council.

53. The performance reports are due within two months of the end of the relevant period.

ATTACHMENT A

National Partnership Agreement on Preventive Health

HEALTHY CHILDREN

Scoping Statement and Guiding Policy Principles

PART 1: INTRODUCTION AND OVERVIEW

1.1 Purpose

This document, developed in consultation with states and territories, is designed to provide guidance in developing jurisdictional implementation plans and support a consistent approach to the implementation of the Healthy Children initiative under the National Partnership Agreement on Preventive Health (NPAPH).

1.2 Objectives

The objective of the NPAPH is to reduce the risk of chronic disease by reducing the prevalence of overweight and obesity, improving nutrition and increasing levels of physical activity in adults, children and young people through the implementation of programs in various settings. The NPAPH provides funding for:

- settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives and focusing on improving poor nutrition, and increasing physical inactivity. For adults also focusing on smoking cessation and reducing harmful and hazardous alcohol consumption;
- social marketing for adults aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the National Preventive Health Agency and research fund.

1.3 Outputs

To realise these objectives, the Healthy Children initiative will fund states and territories to deliver a range of programs:

a) building on existing efforts currently in place, while adapting them to suit demographic and other factors in play at various sites;
b) covering physical activity, healthy eating, primary and secondary prevention;

c) in settings such as child care centres, pre-schools, schools, multi-disciplinary service sites, and children and family centres; and
d) including family based interventions, settings based interventions, environmental strategies in and around schools, and breastfeeding support interventions.

1.4 Evidence Base

The interim results of the Australian Bureau of Statistics *National Health Survey 2007-08* show the proportion of combined overweight or obese children aged 5 -17 years increased from 20.8 per cent in 1995 to 24.9 per cent in 2007-08.[1] Further, results from the 2007 *Australian National Children's Nutrition and Physical Activity Survey* indicate that:

- the proportion of children meeting the guidelines for fruit intake (1-3 serves per day depending on age group and gender) declines with age (61 per cent for 4-8 year olds, 51 per cent for 9-13 year olds and 1- 2 per cent for 14-16 year olds); and
- the proportion of children meeting the guidelines for vegetable intake (2-4 serves per day depending on age group and gender) decreases with age (22 per cent for 4-8 year olds, 14 per cent for 9-13 year olds and 5 per cent for 14-16 year olds).[2]

Key factors emerging from the international and national literature that can determine the success and sustainability of health promotion programs suitable for children and young people include:

- *Well established project planning and implementation* ensures the identified needs and interests of children are met. A participatory approach to planning the program structure and content involving the key influencers in children's lives is beneficial.
- *Recognition of the role of the family and community and involvement in key activities.*
- *A focus on good nutrition and physical activity.*
- *Structural support for healthy lifestyles* including safe places and spaces for physical activity and increased access to healthy food.
- *Effective and consistent communication* of the aims and purpose of the program to build positive engagement.
- *Multi-component programs* can ensure a variety of behavioural risk factors, issues and strategies are addressed to engage greater numbers of children and young people with different preferences and health needs and ensure lasting change.
- *Monitoring and evaluation* of all program components should be established during program planning and inception.

PART 2: HEALTHY CHILDREN

Terminology, Scoping Statement and Guiding Policy Principles

2.1 Terminology

For the purposes of the Healthy Children initiative in the NPAPH, the following terms are defined:

Access and equity is about ensuring that individuals, families and populations are not further disadvantaged in a health and social sense through the programs and activities delivered as part of the NPAPH. It requires consideration of a range of factors that can impact on access to, reach of and appropriateness of programs for certain populations, removing or reducing barriers to health and

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[1] Australian Bureau of Statistics (2009); National Health Survey 2007-08 – Summary of results, Canberra

[2] Australian National University (2007); Children's Nutrition and Physical Activity Survey – Fact Sheet – Key Findings 2007, Canberra

access to health-based activities. Programs must support equity of outcomes for all by increasing opportunities and removing or reducing barriers for participation. There are a number of interacting factors that must be considered in addressing access and equity, for example:

- the size of the organisation or setting and relative capacity to access, take up, participate in and/or be reached by programs and implement programs;
- consideration of the characteristics of children and young people, and their families at both a group and individual level including gender, cultural and linguistic background, Aboriginal and Torres Strait Islanders, people with a disability, physical location and socio-economic status. These factors should be considered in program design, delivery and evaluation;
- equity of outcome that considers all the elements above in relation to the outcomes for individuals (for example, were there organisations and individuals who experienced better results than others in the same cohort); and
- elements outlined in the Australian Government's *Social Inclusion Toolkit.*[3]

Children, for the purposes of this initiative, are defined as children and young people from birth to 16 years of age. Young people between the ages of 16 and 18 years are included in the definition of children if they are not participating in higher education as this setting is best addressed by the Healthy Communities and Healthy Workers initiatives.

Healthy living programs, in the context of this initiative, are those programs that cover physical activity and healthy eating. The use of the term 'program(s)' is inclusive of activities targeting individuals, groups of individuals and of activities that are of an organisational wide, enabling or capacity building nature. This may include policy enhancement, system change and minor supporting infrastructure improvements directly related to the implementation in the specific setting that are made to facilitate and support the health of children and young people and associated with behavioural change. The following language will be used to describe the hierarchy of elements of the NPAPH:

1. NPAPH initiatives, such as Healthy Children;
2. jurisdictional programs (i.e., state and territory programs or activities implemented according to an agreed plan); and
3. activities within jurisdictional programs; local government programs or pilot programs..

Primary and secondary prevention definitions are drawn from *The Language of Prevention*, National Public Health Partnership (2006)[4] and in the context of the Healthy Children initiative mean:

- *Primary prevention* - limiting the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departure from good health, control exposure to risk and promote factors that are protective of good health; and
- *Secondary prevention* – reduction of progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention.

Quality assurance framework, accreditation and standards or other relevant material are already in place and/or currently being developed by the Australian Government under the NPAPH. Programs and program providers will be encouraged to have regards to relevant accreditation processes in order to receive funding under the initiative from jurisdictions.

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[3] www.socialinclusion.gov.au/Documents/SIToolKit.pdf
[4] National Public Health Partnership (2006), *The Language of Prevention*, Melbourne.

2.2 Scope

Consistent with the objectives and expected outcomes of the NPAPH, the policy scope for the Healthy Children initiative is summarised below:

2.2.1 The focus of the initiative is the prevention of lifestyle related chronic disease through addressing the modifiable lifestyle risk factors of poor nutrition and physical inactivity through sustained behaviour change for children and young people.

2.2.2 The primary target group is children and young people and program funding should be directed to these groups taking into account the key role and involvement of the family, particularly parents. Setting based initiatives may involve making the environment more supportive of healthy lifestyles. For example, food and physical activity policies, training of relevant health professionals, curriculum development and activities that target children and their families directly or indirectly through a child care or school setting, and child behaviours through combined parent/child interventions.

2.2.3 Substantial built environment or infrastructure improvements are beyond the scope of the NPAPH and this initiative.

2.2.4 Mental health is not included as a performance benchmark under the NPAPH. While programs may have a mental health element, this should not be the sole focus of the program.

2.2.5 Programs should ensure a positive body image is promoted and that emphasis is on a healthy lifestyle. This should involve consideration of the target audience for programs and individuals and groups who may be vulnerable to forming a negative body image. For example, programs that target groups such as teenage girls may need different support and messages than programs for very young children or for primary school aged children.

2.2.6 Programs should focus on preventive health activities and the promotion of healthy behaviour. Programs with a tertiary management focus (i.e., the clinical management of existing chronic conditions) are not within the preventive scope of this initiative. However, individuals already participating in tertiary treatment programs are not to be excluded. Note that only preventive programs may attract funding.

2.2.7 New and innovative programs can be implemented where gaps exist for children and young people, and their families, or existing programs can be adapted or extended to suit demographic and other factors.

2.2.8 Programs can be delivered in settings such as child care centres, pre-schools, schools, multi-disciplinary service sites, children and family centres and potentially other less formal settings such as play groups or youth sporting groups.

2.2.9 Programs may take the form of settings based initiatives, strategies in and around schools and early childhood settings, and breastfeeding support interventions. Programs must focus on delivery of activities within the defined setting. Delivery of program activities exclusively in the home is not within the scope of the initiative.

2.2.10 Programs should actively support breastfeeding, where relevant.

2.3 Policy Principles

General

2.2.1 Programs under the initiative should be focused on primary and secondary prevention.

2.2.2 Funding for programs should be invested in:

- significant enhancements or expansions to existing program(s) that have already demonstrated they are efficacious;
- new programs that have demonstrated efficacy elsewhere that are directly translatable to the initiative setting;
- programs that can demonstrate significant innovation and/or promise from initial results, but lack formal evidence to demonstrate effectiveness; and/or
- programs that have a high likelihood of being sustainable beyond the funding received under this initiative (should the program be effective and there is a demonstrated continuing need).

2.2.3 Programs should reflect the requirements of the Australian Government's *Social Inclusion Toolkit*.

2.2.4 Access and equity in terms of both access to programs and equity of outcomes as a result of participation in programs must be a key consideration.

2.2.5 Participation in NPAPH programs is voluntary. However, the voluntary participation requirement does not override specifications of existing or new setting-based legislative requirements or policies (e.g., food supply, curriculum, and requirements for physical activity).

2.2.6 Programs and associated evaluations should not further stigmatise obesity and other applicable health conditions and behaviours and should promote a positive body image. Programs should also consider the potential for any negative body image messages and have appropriate management strategies in place.

2.2.7 Measures must be in place to protect the privacy of individuals as appropriate. Programs must comply with applicable legislation in relation to consent to collect personal and health information and the use, access, storage and disclosure of this information.

2.2.8 Program providers may be expected to comply with specified requirements, including quality assurance frameworks, standards or other guidance in existence or currently being developed under the NPAPH.

2.2.9 Programs should be developed and implemented in consideration of relevant local enablers and barriers (i.e. appropriate stakeholder consultation and support, infrastructure issues and different industry and workforce requirements).

2.2.10 Funding under the initiative may be used to extend existing programs or create new programs. However, the duplication of funding already allocated at a state and territory level, or by an organisation should not be permitted.

2.2.11 Programs will not be funded if they support, promote or utilise sponsorship of food or beverage products considered to be high in sugar, salt and saturated fat, or of tobacco and/or alcohol or promote sedentary behaviour.

2.2.12 Consistency and complementarity with programs already in place should be considered. An assessment of possible efficiencies and effectiveness should be undertaken that recognises activities in other settings (i.e. the community and workplaces).

2.2.13 Programs should have monitoring systems in place to ensure they are capable of reporting in an accurate and timely way on the achievement of program outputs in accordance with performance monitoring and evaluation requirements under the NPAPH.

2.2.14 Programs should have mechanisms in place for continuous quality improvement. Monitoring and evaluation arrangements should, where possible, be developed to help facilitate evaluation at a national level.

And specifically for the Healthy Children initiative

2.2.15 Programs that have a clinical risk assessment component should have identified clear and appropriate referral pathways in place that include complementary support activities that aim to address and lead to a reduction in identified lifestyle risk factors.

2.2.16 Programs should emphasise the importance of healthy lifestyles, good nutrition and regular physical activity and should include a comprehensive mix of interventions. This includes both universal approaches and targeted interventions for children and young people who may be at high risk of overweight/obesity, physical inactivity and/or have poor nutrition.

2.2.17 Consideration should be given to populations of children and young people at higher risk of overweight or obesity, physical inactivity and/or poor nutrition, in particular socioeconomically disadvantaged populations and Aboriginal and Torres Strait Islander communities.

2.2.18 Programs should complement existing effective programs and policies for children and young people.

2.2.19 Programs should explicitly support breastfeeding where relevant.

2.2.20 Programs should comply with requirements for working with children and young people in each state and territory.

2.2.21 Programs must be safe and appropriate for children and young people and their parents and families.